NAME OF YOUR FACILITY: _____

FACILITY PLAN FOR ENSURING THE RESIDENT'S NEEDS CAN BE MET

Resident Name: _____

- All medication management will be followed as directed by the Physician and documented accordingly.
- Any and all adverse reactions to any medication or observed changes in the physical and/or mental condition of the resident will be documented and the appropriate individuals will be notified in a timely manner (Physician, Hospice/Home-Health Nurse, Family)
- Resident will be turned or assisted in position change every 2 hours, or as needed, or as directed by the physician &/or hospice/ home health agency.
- Bedside feeding or assistance will be provided by facility staff members as needed
- Diet as prescribed by the resident's physician will be followed
- Facility staff will regularly conduct checks for need of changing or assistance with incontinence care

TRAINING:

Facility staff have received current training for: (check all that apply)

_____ Repositioning a bedfast resident

_____ Incontinence Care

_____ Signs and symptoms of urinary tract infection

_____ Signs and symptoms of other infections

_____ Signs and symptoms of dehydration

_____ Infection control/ prevention – Proper Hand washing procedures

_____ Other: Please describe: _____

_____

_____

_____

Attestation:

By signing this notice, I accept the responsibility to ensure the care and needs of this resident will be met by the caregivers of this facility.

Signature of Administrator: _____

Print Name of Administrator: _____

Date: _____